Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968003	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLANTE OF MELBOURNE	964 S HARBOUR CITY BLVD MELBOURNE, FL 32901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation #2025001768 and generator monitoring were conducted at Volante of Melbourne Assisted Living Facility. There was a deficiency identified at the time of the survey.	A 000		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require	A 055		

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A 055	Continued From page 1 central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are	A 055		

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A 055	Continued From page 2 still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep in a locked cabinet; locked cart; or other locked storage receptacle at all times for 1 of 4 residents sampled (#1). Findings: On unlicensed caregiver (B) received medication from the pharmacy delivery driver. A review of the pharmacy manifestation dated at 10:09 pm revealed the delivery included 28 tablets of , IR 20mg. On at 11:44 am an interview with unlicensed caregiver (A) was conducted. She said on around 4:30 pm she was notified that resident #1 was low on , and he would need a refill. It is the facility practice to notify her if there are medications that need to be reordered. She said she called the pharmacy, and they told her the medication had already been delivered on . She said that was when they realized the was missing.	A 055		

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A 055	Continued From page 3 She, the Administrator, and the Director of Nursing (DON) searched for the medication, but did not find it. She notified his Primary Care Provider. A review of resident #1's record revealed he was admitted to the facility on . The record contained a resident health assessment form (1823) dated . The resident diagnoses included , and , . The resident was assessed to need assistance with self-administration of medication. The resident's record contained a prescription for 20mg , every 6 hours for , . On at 1:23 pm an interview with unlicensed caregiver B was conducted. She said she answered the doorbell on Friday for the pharmacy delivery around 11pm. She signed for 3 medications. One of the medications was , for resident #1. She signed 1 pharmacy requisition for each card of medications. She said she then took the medications to the nurse's office and put them on the second desk. She said she closed the door which locks when closed. She said before this incident the facility practice was to leave medications and requisitions on the desk in the nurse's office. She said when she was hired, that is what she was trained to do. Everyone left medication on the desk. After the , went missing, there was an in-service on the facility policy. Now two people must witness being added to the locked medication cart. When she left the morning of she did not notice if the medications were still on the desk. She said she just dropped off her walkie talkie and left. She said she did not know where the medications went. She put them on the desk	A 055		

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A 055	Continued From page 4 on Friday, but she was not called until Monday. On at 1:40pm an interview with unlicensed caregiver D was conducted. She said she never saw the medications on the desk in the nurse's station after being delivered on . She said before the medication went missing, it was the facility practice to place the medications on the desk in the nurse's office after receiving them from the pharmacy. After the missing medication, they put them in the locked medication cart. On at 2:15 pm in an interview with unlicensed caregiver F she said she did not see medications on the desk. She worked shift. She only went to the office to get a walkie talkie. She said before the medication went missing, it was the facility practice to put medications on the desk in the nurse's office and lock the door. Now they have to put them in the medication cart. A review of the facility policy dated titled - , controlled substance, and preventing drug diversion read: Medications are stored in a secure manner. Special storage and security guidelines will be followed to protect controlled substances ( ) and to help prevent drug diversion. 1. All medications, including OTC medications, are kept in locked storage. and controlled substances are to be kept double locked. On at 2pm an interview with the DON was conducted. She said she was not aware of a different facility practice prior to resident #1's missing medication. During the day they take all the medications from the pharmacy and put them in the locked medication carts. She confirmed	A 055		

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A 055	Continued From page 5 she conducted an in-service on the facility policy to secure all medications. Class III	A 055		